STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155226	A. BUILDING _____ B. WING _____	C 08/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH CAPITOL NURSING & REHABILITATION CENTER	2010 N CAPITOL AVE INDIANAPOLIS, IN 46202

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS This visit was for the Investigation of Complaint IN00154978. This visit was in conjunction with the Recertification and State Licensure Survey and the Investigation of Complaint IN00153701. Complaint IN00154978 - Unsubstantiated due to lack of evidence. Survey dates: August 20 and 21, 2014. Facility number: 000131 Provider number: 155226 AIM number: 100274910 Survey team: Tim Long, RN - TC Rick Blain, RN Randy Fry, RN Carol Miller, RN Diane Nilson, RN Census bed type: SNF/NF: 117 Total: 117 Census payor type: Medicare: 17 Medicaid: 88 Other: 12 Total: 117 Sample: 3 North Capitol Nursing and Rehabilitation Center was found to be in compliance with 42 CFR Part	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 000	Continued From page 1 483, Subpart B and 410 IAC 16.2-3.1 in regard to the Investigation of Complaint IN00154978. Quality review completed 8/25/14 by Brenda Marshall, RN.	F 000		